

DELAWARE MEDICAL ASSISTANCE PROGRAM (DMAP)
PREFERRED DRUG LIST (PDL)

Effective: 1/1/2017; Updated: 12/15/2016

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ACNE AGENTS, TOPICAL			
PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**	
PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	<u>2 preferred medications are required before a non-preferred will be approved</u>	
clindamycin gel, solution erythromycin gel, solution erythromycin/benzoyl peroxide tretinoin cream tretinoin 0.01, 0.025% gel Azelex Duac			
adapalene benzoyl peroxide clindamycin foam, lotion, swab clindamycin/benzoyl peroxide clindamycin/tretinoin erythromycin swab sulfacetamide sodium sodium sulfacetamide/sulfur tretinoin 0.05% gel tretinoin microsphere		Acanya Aczone Benzepro BP Foaming Wash Clindacin ETZ Clindacin PAC Differin ▲ Epiduo ▲ Epiduo Forte ▲ Fabior	Klaron Neutac Onexton Panoxyl SSS-10-5 Sulfacleanse Sumadan Sumaxin Tazorac
ALZHEIMER'S AGENTS Clinical criteria apply to class. All agents require a prior authorization.			
PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**	
PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	<u>2 preferred medications are required before a non-preferred will be approved</u>	
donepezil 5, 10 mg memantine tablets Exelon patch	donepezil ODT donepezil 23mg galantamine galantamine ER memantine solution rivastigmine Namenda XR Namzaric	Prior Authorization forms available on the web at : www.dmap.state.de.us/downloads/pharmacy/paforms/Cholinesterase.Inhibitor.pdf	<u>Please note:</u> brand name drugs with a generic available are considered nonpreferred unless listed in bold. ▲ – indicates that the manufacturer does not participate in all DMMA programs.
ANALGESICS, NARCOTIC LONG ACTING Clinical criteria apply to class. All agents require a prior authorization.			
PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**	
PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	<u>2 preferred medications are required before a non-preferred will be approved</u>	
fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets tramadol ER (gen. Ultram ER) Embeda	fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER morphine ER capsules oxycodone ER	oxymorphone ER tramadol ER (gen. ConZip) Belbuca Butrans	Hysingla ER Kadian Nucynta ER Xartemis XR Zohydro ER
Prior Authorization forms available on the web at: www.dmap.state.de.us/information/paforms.html			

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ANALGESICS, NARCOTIC SHORT ACTING

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
<p>Preferred status implementation: 1/1/17</p> <p>butalbital compound /codeine codeine codeine/APAP hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablets morphine tabs/solution oxycodone tablets oxycodone/APAP pentazocine/APAP tramadol</p>	<p>Prior authorization is required</p> <p>butorphanol nasal carisoprodol compound dihydrocodeine/APAP /caffeine dihydrocodeine/ASA/ caffeine fentanyl lozenge ● hydromorphone liquid, suppositories levorphanol meperidine morphine concentrate, suppositories</p> <p>oxycodone/ASA oxycodone concentrate oxycodone/ibuprofen oxymorphone pentazocine/naloxone tramadol/APAP Abstral Fentora Lortab solution Nucynta Primlev Reprexain Subsys Xylon</p>	<p><u>2 preferred medications are required before a non-preferred will be approved</u></p> <p>-Quantity limits in place:</p> <ul style="list-style-type: none"> ➢ oxycodone 15mg maximum of 240 units a year ➢ oxycodone 20mg maximum of 120 units a year ➢ oxycodone 30 mg maximum of 60 units a year ➢ 120 short-acting units per 30 days with a total of 720 short-acting units a year ➢ DMMA recommends that first fill of new pain medication be limited to 15 supply <p>—Clinical criteria apply. A clinical prior authorization is required: www.dmap.state.de.us/information/paforms.html</p>

ANDROGENIC AGENTS, TOPICAL

Clinical criteria apply to class. All agents require a prior authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
<p>Preferred status implementation: 1/1/17</p> <p>Androgel packet, pump ●</p>	<p>Prior authorization is required</p> <p>testosterone ● Androderm ●</p> <p>Axiron ● Natesto ● Vogelxo ●</p>	<p>—Clinical criteria apply. A clinical prior authorization is required despite the medication's status as preferred or nonpreferred: www.dmap.state.de.us/downloads/pharmacy/paforms/Testosterone.Suplementation.pdf</p>

ANGIOTENSIN MODULATORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
<p>Preferred status implementation: 1/1/17</p> <p>benazepril / HCTZ losartan / HCTZ enalapril / HCTZ ramipril Epaned lisinopril / HCTZ</p>	<p>Prior authorization is required</p> <p>candesartan/HCTZ captopril / HCTZ eprosartan fosinopril / HCTZ irbesartan / HCTZ</p> <p>moexipril / HCTZ olmesartan / HCTZ quinapril / HCTZ perindopril telmisartan / HCTZ</p> <p>trandolapril Edarbi / Edarbyclor Entresto Tekturna / HCT Teveten / HCT</p>	<p><u>2 preferred medications are required before a non-preferred will be approved</u></p> <p>Dose optimization required when applicable</p>

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ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 amlodipine/benzazepril amlodipine/valsartan Exforge HCT	Prior authorization is required telmisartan/amlodipine trandolapril/verapamil valsartan/amlodipine/HCTZ Azor ▲	<u>2 preferred medications are required before a non-preferred will be approved</u> Dose optimization required when applicable ▲— indicates that the manufacturer does not participate in all DMMA programs. Please note: brand name drugs with a generic available are considered nonpreferred unless listed in bold.

ANTIBIOTICS, GI

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 metronidazole tablets neomycin	Prior authorization is required metronidazole capsules paromomycin capsules vancomycin	<u>•—Clinical criteria apply.</u> A clinical prior authorization is required despite the medication's status as preferred or nonpreferred. Patients must try and fail lactulose before Xifaxan is approved for appropriate diagnoses. ▲— indicates that the manufacturer does not participate in all DMMA programs.

ANTIBIOTICS, INHALED

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 01/1/17 Bethkis Kitabis Pak	Prior authorization is required tobramycin Cayston TOBI Podhaler	

ANTIBIOTICS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 bacitracin bacitracin/polymyxin gentamicin mupirocin ointment triple antibiotic ointment	Prior authorization is required mupirocin cream neomycin/bacitracin/polymyxin/ pramoxine neomycin/polymyxin/pramoxine	<u>2 preferred medications are required before a non-preferred will be approved</u>

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ANTIBIOTICS, VAGINAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 clindamycin metronidazole Cleocin ovules	Prior authorization is required Clindesse Metrogel-Vaginal Nuvessa Vandazole	<u>2 preferred medications are required before a non-preferred will be approved</u>

ANTICOAGULANTS, ORAL/SQ

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**
Preferred status implementation: 1/1/17 enoxaparin warfarin Eliquis ● Fragmin▲ Pradaxa ● Xarelto ●	fondaparinux Savaysa	<u>2 preferred medications are required before a non-preferred will be approved</u> -Quantity limits in place on injectable formulations: 10 days allowed without prior authorization ▲— indicates that the manufacturer does not participate in all DMMA programs. ● Eliquis, Pradaxa and Xarelto require diagnosis code

ANTICONVULSANTS, ORAL/RECTAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***				
Preferred status implementation: 01/1/17 carbamazepine tablets, chewable carbamazepine ER, XR clonazepam tablet divalproex sodium solution ethosuximide solution gabapentin lamotrigine IR	levetiracetam IR. solution oxcarbazepine phenobarbital phenytoin primidone topiramate tablets, sprinkle valproic acid zonisamide	Celontin Diastat Gabitril Peganone▲ Tegretol Suspension	carbamazepine suspension clonazepam ODT diazepam rectal ethosuximide caps felbamate lamotrigine ER, ODT levetiracetam ER tiagabine tablets topiramate ER	Aptiom Banzel ▲ Briviact Epitol Equetro Fycompa Gralise	Lyrica ● Onfi Oxtellar XR Potiga Sabril Spritam Stavzor Trokendi XR Vimpat	<u>2 preferred medications are required before a non-preferred will be approved</u> Quantity limits in place: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization. Brand name narrow therapeutic drugs automatically pay for seizure clients with seizure diagnosis in medical history Please note: brand name drugs with a generic available are considered nonpreferred unless listed in bold. ▲— indicates that the manufacturer does not participate in all DMMA programs. —Clinical criteria will still apply: Prior Authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Pregabalin.Lyrica.pdf

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ANTIDEPRESSANTS, OTHER

PREFERRED AGENTS			NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17			Prior authorization is required			
bupropion mirtazapine tab tranylcypromine	trazodone venlafaxine venlafaxine ER caps	Marplan	desvenlafaxine ER desvenlafaxine fumarate ER mirtazapine ODT nefazodone	phenelzine venlafaxine ER tablets Aplenzin Emsam Fetzima	Forfivo XL Oleptro Trintellix Viibryd	<p><u>2 preferred medications are required before a non-preferred will be approved</u></p> <p>DMAP requires prior authorization for the following products for the pediatric patient under six (6) years of age. Prior authorization forms available on the web at: www.dmap.state.de.us/information/paforms.html</p>

ANTIDEPRESSANTS, SSRIs

PREFERRED AGENTS			NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17			Prior authorization is required			
citalopram escitalopram tablet fluoxetine capsules fluvoxamine tablets	paroxetine tablets sertraline		escitalopram solution fluoxetine tablet fluoxetine 60mg fluoxetine weekly fluvoxamine ER paroxetine CR paroxetine suspension	Brisdelle Pexeva		<p><u>2 preferred medications are required before a non-preferred will be approved</u></p> <p>DMAP requires prior authorization for the following products for the pediatric patient under six (6) years of age. Prior authorization forms available on the web at: www.dmap.state.de.us/information/paforms.html</p> <p>Liquid medications require prior authorization for clients over 10 years old.</p>

ANTIEMETICS

PREFERRED AGENTS			NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17			Prior authorization is required			
ondansetron ODT ondansetron tablets	dronabinol● granisetron ondansetron solution Akyunzeo Anzemet Cesamet		Diclegis ● Emend Sancuso Varubi Zuplenz			<p>● –Clinical criteria will still apply: indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred available at: www.dmap.state.de.us/information/paforms.html</p>

ANTIFUNGALS, ORAL

PREFERRED AGENTS			NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17			Prior authorization is required			
fluconazole griseofulvin suspension nystatin terbinafine	clotrimazole flucytosine griseofulvin tablets griseofulvin ultramicrosize		itraconazole ketoconazole voriconazole Cresemba Lamisil	Noxafil ▲ Onmel Oravig ^{NR} Sporanox		<p><u>2 preferred medications are required before a non-preferred will be approved</u></p> <p>▲– indicates that the manufacturer does not participate in all DMMA programs.</p>

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ANTIFUNGALS, TOPICAL

PREFERRED AGENTS		NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required			
ciclopirox solution	nystatin	ciclopirox cream, gel,	oxiconazole	Jublia	<u>2 preferred medications are required before a non-preferred will be approved</u>
clotrimazole	nystatin/triamcinolone	shampoo, suspension	terbinafine	Kerydin Lamisil	▲ – indicates that the manufacturer does not participate in all DMMA programs.
ketoconazole cream, shampoo		clotrimazole/ betamethasone	Alevazol ^{NR}	Loprox	
		econazole	Ciclodan	Luzu	
		ketoconazole foam	Ertaczo	Mentax	
		miconazole	Exelderm	Naftin	
		naftifine	Fungoid	Vusion	

ANTIHEMOPHILIC FACTOR VIII

PREFERRED AGENTS		NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required			
Advate	Adynovate		Kogenate FS		<u>2 preferred medications are required before a non-preferred will be approved</u>
Afstyla	Eloctate		Kovaltry		
Alphanate	Helixate FS		Novoeight		
Humate-P	Hemofil M		Nuwiq		
Monoclate-P	Koate-DVI		Xyntha		
Recombinate					

ANTIHEMOPHILIC FACTOR iX

PREFERRED AGENTS		NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required			
Alphanine SD	Mononine	Alprolix			<u>2 preferred medications are required before a non-preferred will be approved</u>
Benefix	Rixubis	Idelvion			
Ixinity					

ANTIHISTAMINES, MINIMALLY SEDATING

PREFERRED AGENTS		NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required			
cetirizine solution OTC / Rx	cetirizine chewable		levocetirizine syrup, tablets		<u>2 preferred medications are required before a non-preferred will be approved</u>
cetirizine tablets OTC	cetirizine-D OTC		loratadine ODT		▲ – indicates that the manufacturer does not participate in all DMMA programs.
loratadine tablets OTC, solution	desloratadine		loratadine-D OTC		
	desloratadine ODT		Clarinet-D ▲		
	fexofenadine OTC		Semprex-D		
	fexofenadine / fexofenadine-D				

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ANTIHYPERTENSIVES, SYMPATHOLYTIC

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 clonidine guanfacine	Prior authorization is required clonidine transdermal reserpine	<u>2 preferred medications are required before a non-preferred will be approved</u> Please note: Brand name drugs with a generic available are considered nonpreferred unless listed in bold.

ANTIHYPERURICEMICS, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 allopurinol Mitigare● probenecid probenecid with colchicine	Prior authorization is required colchicine● Uloric Zurampic ^{NR}	●Clinical criteria apply to colchicine with approval for treatment, not prophylaxis

ANTIMIGRAINE AGENTS, TRIPTANS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 rizatriptan, rizatriptan ODT sumatriptan tablets Imitrex nasal spray	Prior authorization is required almotriptan frovatriptan naratriptan sumatriptan nasal spray, injection zolmitriptan, zolmitriptan ODT Cambia	<u>2 preferred medications are required before a non-preferred will be approved</u> -Quantity limits in place: Nine (9) tablets per 45 days Please note: Brand name drugs with a generic available are considered nonpreferred unless listed in bold.

ANTIPARASITICS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 permethrin piperonyl butoxide/pyrethrins Natroba	Prior authorization is required lindane malathion spinosad	Please note: brand name drugs with a generic available are considered nonpreferred unless listed in bold. ▲— indicates that the manufacturer does not participate in all DMMA programs.

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ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***			
Preferred status implementation: 1/1/17 benztropine carbidopa/levodopa IR, ER pramipexole IR	ropinirole IR selegiline tablets trihexyphenidyl	Prior authorization is required bromocriptine carbidopa carbidopa/levodopa ODT carbidopa/levodopa/entacapone	entacapone pramipexole ER ropinirole XL selegiline capsules tolcapone	Azilect Duopa Neupro Rytary Zelapar	<u>2 preferred medications are required before a non-preferred will be approved</u>

ANTIPSORIATIC AGENTS, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 Soriatane	acitretin methoxsalen	Prior authorization is required Please note: Brand name drugs with a generic available are considered nonpreferred unless listed in bold

ANTIPSORIATIC AGENTS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 calcipotriene	Prior authorization is required calcipotriene/betamethasone calcitriol Enstilar Taclonex Tazorac	

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ANTIPSYCHOTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
<p>Preferred status implementation: 1/1/17</p> <p>amitriptyline / perphenazine ariprazole tablets (step-edit) chlorpromazine clozapine fluphenazine fluphenazine decanoate Geodon IM● haloperidol decanoate haloperidol concentrate, solution, tablets loxpipime olanzapine injection, tablets perphenazine quetiapine</p> <p>risperidone solution, tablets thioridazine thiothixene trifluoperazine ziprasidone Abilify Maintena ● Invega Sustenna● Invega Trinza ● Molan Orap Risperdal Consta● Seroquel XR (step-edit)</p>	<p>ariprazole ODT clozapine ODT haloperidol lactate injection molindone olanzapine ODT olanzapine / fluoxetine paliperidone ER pimozide risperidone ODT</p>	<p>Prior authorization is required</p> <p>Ability injection Adasuve Aristada ● Fanapt Latuda* Rexulti Saphris Versacloz Zyprexa Relprevv●</p> <p>DMAP requires prior authorization for the following products for the pediatric patient under six: www.dmap.state.de.us/information/paforms.html</p> <p>All long acting injectable antipsychotics require prior authorization, forms are available at the following link: www.dmap.state.de.us/downloads/pharmacy/paforms/Risperidone.Injection.pdf</p> <p>Please note: Brand name drugs with a generic available are considered nonpreferred unless listed in bold</p> <p>* (grandfathered) clients currently receiving medication at implementation date may continue without prior authorization.</p> <p>Aripiprazole, Seroquel XR new starts will pay electronically if a client has tried and failed a different generic atypical antipsychotic first.</p> <p>● - indicates oral therapy is required before injectable will be approved</p>

ANTIVIRALS, ANTIRETROVIRALS

PREFERRED AGENTS	NON-PREFERRED AGENTS
<p>Preferred implementation: 1/1/17</p> <p>abacavir didanosine lamivudine lamivudine-zidovudine nevirapine nevirapine ER stavudine zidovudine Complera Crixivan Descovy Edurant Emtriva Epzicom Evotaz Fuzeon Genvoya Intelence Invirase Isentress Kaletra Lexiva</p> <p>Norvir Odefsey Prezcobix Prezista Rescriptor Retrovir Reyataz Selzentry Stribild Sustiva Tivicay Trizivir Truvada Tybost Videx Videx EC Viracept Viread Vitekta Zerit solution Ziagen solution</p>	<p>Prior authorization is required</p> <p>Triumeq</p>

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ANTIVIRALS, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 acyclovir amantadine capsules famciclovir	NON-PREFERRED AGENTS Prior authorization is required amantadine tablets rimantadine Tamiflu ▲ Sitavig	<u>2 preferred medications are required before a non-preferred will be approved</u> Liquid medications require prior authorization for clients over 10 years old <u>-Quantity limits in place for Tamiflu and Relenza</u> ▲— indicates that manufacturer does not participate in all DMMA programs.

ANTIVIRALS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 Abreva Zovirax cream	NON-PREFERRED AGENTS Prior authorization is required acyclovir ointment Denavir Xerese	

ANXIOLYTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 alprazolam tablets buspirone chlordiazepoxide clorazepate	NON-PREFERRED AGENTS Prior authorization is required alprazolam ER alprazolam Intensol alprazolam ODT diazepam intensol	<u>2 preferred medications are required before a non-preferred will be approved</u> lorazepam Intensol meprobamate oxazepam Quantity Limits of 120 units of benzodiazepines per 30 days. Clinical criteria apply: indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred available at: www.dmap.state.de.us/information/paforms.html

BETA BLOCKERS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 atenolol atenolol/chlorthalidone bisoprolol bisoprolol/HCTZ carvedilol labetalol	NON-PREFERRED AGENTS Prior authorization is required metoprolol metoprolol XL propranolol propranolol/HCTZ propranolol ER sotalol acebutolol betaxolol metoprolol/HCTZ nadolol nadolol/bendroflumethiazide pindolol timolol Bystolic Coreg CR Dutoprol Hemangeol Innopran XL Levatol Sotyline	<u>2 preferred medications are required before a non-preferred will be approved</u>

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BILE SALTS

PREFERRED AGENTS Preferred status implementation: 1/1/17 ursodiol	NON-PREFERRED AGENTS Prior authorization is required Chenodal Cholbam	CRITERION***
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BLADDER RELAXANT PREPARATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/17 oxybutynin oxybutynin ER Vesicare	NON-PREFERRED AGENTS Prior authorization is required darifenacin tolterodine tolterodine ER trospium trospium ER	CRITERION*** <u>2 preferred medications are required before a non-preferred will be approved</u>
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BONE RESORPTION SUPPRESSION AND RELATED AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17 alendronate tablets calcitonin-salmon nasal spray	NON-PREFERRED AGENTS Prior authorization is required alendronate solution etidronate Ibandronate risedronate	CRITERION***
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BPH TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17 alfuzosin doxazosin finasteride tamsulosin	NON-PREFERRED AGENTS Prior authorization is required dutasteride dutasteride/tamsulosin Cardura XL Rapaflo	CRITERION*** <u>2 preferred medications are required before a non-preferred will be approved</u>
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BRONCHODILATORS, BETA AGONIST

PREFERRED AGENTS Preferred status implementation: 1/1/17 albuterol nebulizer solution, syrup terbutaline ProAir HFA Proventil HFA Serevent	NON-PREFERRED AGENTS Prior authorization is required albuterol ER albuterol tablets levalbuterol metaproteranol Arcapta Brovana	CRITERION*** <u>2 preferred medications are required before a non-preferred will be approved</u>
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CALCIUM CHANNEL BLOCKERS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 amlodipine diltiazem IR diltiazem ER capsules felodipine nicardipine	NON-PREFERRED AGENTS Prior authorization is required diltiazem ER tablets isradipine nimodipine (ICD-10 code for SAH may create system-generated approval) nisoldipine	<u>2 preferred medications are required before a non-preferred will be approved</u> -Requires dose optimization when applicable ▲— indicates that the manufacturer does not participate in all DMMA programs

CEPHALOSPORINS AND RELATED ANTIBIOTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 amoxicillin/clavulanate suspension, tablets cefaclor capsules cefadroxil tablets cefdinir cefprozil	NON-PREFERRED AGENTS Prior authorization is required amoxicillin/clavulanate XR cefaclor tablets cefadroxil suspension, tablets cefditoren cefixime	<u>2 preferred medications are required before a non-preferred will be approved</u>

COPD AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 albuterol/ipratropium nebulizer solution ipratropium nebulizer solution Combivent Respimat Spiriva Handihaler	NON-PREFERRED AGENTS Prior authorization is required Anoro Ellipta Atrovent HFA Combivent Daliresp	• -Clinical criteria will apply

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COUGH and COLD

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 guaiifenesin liquid OTC guaiifenesin DM liquid OTC guaiifenesin ER tablets guaiifenesin/codeine syrup hydrocodone/chlorpheniramine susp hydrocodone/homatropine syrup promethazine DM syrup promethazine/codeine syrup phenylephrine tablets pseudoephedrine liquid, tablets Bromfed DM syrup	NON-PREFERRED AGENTS All other cough/cold products non-preferred	<u>2 preferred medications are required before a non-preferred will be approved</u> -Quantity limits in place: 240ml of narcotic cough suppressants per 30 days and 480ml per 90 days without a comorbid diagnosis. 120ml per 84 days and 900ml/year for Tussionex

COLONY STIMULATING FACTORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
PREFERRED AGENTS Preferred status implementation: 1/1/17 Neupogen	NON-PREFERRED AGENTS Prior authorization is required Granix Leukine Neulasta Zarxio	

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CONTRACEPTIVES, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 desogestrel-ethinyl estradiol norethindrone 1-ethinyl estradiol desogestrel-ethinyl estradiol-ethinyl estradiol 7X3 norethindrone 0.4-ethinyl estradiol ethinyl estradiol norgestimate-ethinyl estradiol acetate-ethinyl estradiol 21-5 levonorgestrel-ethinyl estradiol norethindrone 0.4-ethinyl estradiol/iron levonorgestrel-ethinyl estradiol norethindrone 0.8-ethinyl estradiol/iron norethindrone 1-ethinyl estradiol/iron (24) norethindrone 1-ethinyl estradiol/iron (24) Microgestin FE norgestrel-ethinyl estradiol Necon 7X3 Beyaz Seasonique Lo Loestrin Fe Trinessa Minastrin Yaz Mircette* Natazia Necon 10-11 Norinyl Quartette Safyral	Prior authorization is required ethinyl estradiol/drospirenone levonorgestrel-ethinyl estradiol extended cycle norethindrone 0.4-ethinyl estradiol norethindrone acetate-ethinyl estradiol norethindrone 0.4-ethinyl estradiol/iron norethindrone 0.8-ethinyl estradiol/iron norethindrone 1-ethinyl estradiol/iron (24) norgestrel-ethinyl estradiol Beyaz Lo Loestrin Fe Minastrin Mircette* Natazia Necon 10-11 Norinyl Quartette Safyral	All emergency oral contraceptives are covered without any prior authorization. <u>2 preferred medications are required before a non-preferred will be approved</u> * Class is grandfathered, meaning clients currently receiving medication at implementation date may continue without prior authorization.

CYTOKINE AND CAM ANTAGONISTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 Enbrel (diagnosis code required) Humira (diagnosis code required)	Prior authorization is required Actemra Amevive▲ Arcalyst Cimzia Cosentyx Entyvio Ilaris Kineret Orencia Otezla Remicade Simponi Simponi Aria Stelara Taltz ^{NR} Xeljanz Xeljanz XR	Approved diagnosis code required on prescription and electronic submissions. ▲-- indicates that the manufacturer does not participate in all DMMA programs.

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DIABETIC TESTING BLOOD GLUCOSE METERS, TEST STRIPS, LANCETS

PREFERRED AGENTS Preferred Status implementation 1/1/17	NON-PREFERRED AGENTS Prior authorization is required All other diabetic meters and test strips are non-preferred	CRITERION***
DIURETICS		
PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
amiloride-HCTZ bumetanide chlorothiazide furosemide	hydrochlorothiazide indapamide spironolactone spirololactone-HCTZ triaterene-HCTZ	acetazolamide amiloride chlorthalidone methazolamide methyclothiazide metolozone torsemide Diamox Sequels Diuril Edecrin Microzide Neptazane
EPINEPRINE, SELF-INJECTED		
PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
epinephrine injection EpiPen		
ERYTHROPOIESIS STIMULATING PROTEINS		
Clinical criteria apply to class. All agents require a prior authorization.		
PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Aranesp Epogen Procrit		Prior authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Epoetin.Alpha.pdf
FLUOROQUINOLONES		
PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
ciprofloxacin tablets levofloxacin tablets	ciprofloxacin ER ciprofloxacin suspension levofloxacin solution moxifloxacin ofloxacin	<u>2 preferred medications are required before a non-preferred will be approved</u>

DELAWARE MEDICAL ASSISTANCE PROGRAM (DMAP)

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PREFERRED AGENTS Preferred status implementation: 1/1/17 Amitiza	NON-PREFERRED AGENTS Prior authorization is required Linzess Movantik Relistor	<u>Trial of preferred medication required before non-preferred medication will be approved</u>
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GLUCOCORTICOIDS, INHALED

PREFERRED AGENTS Preferred status implementation: 1/1/17 Advair Diskus (step-edit) ● Asmanex▲ QVAR Pulmicort Respules 0.25 mg & 0.5 mg (age 6 and under or clients with diagnoses on file indicating developmental delays may create a system generated approval) Symbicort (step-edit) ●	NON-PREFERRED AGENTS Prior authorization is required budesonide inhalation solution Advair HFA Aerospan Alvesco Asmanex HFA Arnuity Ellipta Breo Ellipta Dulera Flovent, Flovent HFA Pulmicort Flexhaler Pulmicort Respules 1 mg	CRITERION*** ●—Clinical criteria apply age 6 and under or clients with diagnoses on file indicating developmental delays may create a system generated approval for Pulmicort respules ● indicates that a prior authorization will generate if client has previously failed single agent corticosteroid or long-acting beta agonist inhaler in previous 90 days. Other information and form available on the web at: www.dmap.state.de.us/information/paforms.html ▲— indicates that the manufacturer does not participate in all DMMA programs.
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GLUCOCORTICOIDS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/17 budesonide EC dexamethasone solution / tablet hydrocortisone methylprednisolone dose pack methylprednisolone 4mg tablets prednisolone sodium phosphate prednisolone solution prednisone solution / tablets Orapred ODT	NON-PREFERRED AGENTS Prior authorization is required cortisone dexamethasone elixir, intensol fludrocortisone methylprednisolone 18,16,32 mg tablet prednisolone sodium phosphate ODT prednisone dose pack, intensol Dexpak Millipred Rayos Uceris Veripred	CRITERION*** <u>2 preferred medications are required before a non-preferred will be approved</u>
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DELAWARE MEDICAL ASSISTANCE PROGRAM (DMAP)

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GROWTH HORMONES		
Clinical criteria apply to class. All agents require a prior authorization.		
PREFERRED AGENTS Preferred status implementation: 1/1/17 Norditropin ● Nutropin AQ ●	NON-PREFERRED AGENTS Genotropin ● Humatropin▲ ● Omnitrope ● Saizen ● Prior authorization is required	CRITERION** <u>2 preferred medications are required before a non-preferred will be approved</u> Prior authorization available at: www.dmap.state.de.us/downloads/pharmacy/paforms/Growth.Hormone.Drug.pdf ▲— indicates that the manufacturer does not participate in all DMMA programs
H. PYLORI TREATMENTS		
PREFERRED AGENTS Preferred status implementation: 1/1/17 Pylera	NON-PREFERRED AGENTS Lansporazole-amoxicillin-clarithromycin Omeclamox Pak Prior authorization is required	CRITERION**
HAE TREATMENTS		
Clinical criteria apply to class. All agents require a prior authorization.		
PREFERRED AGENTS Preferred status implementation: 1/1/17 Berinert Danazol Firazyr Kalbitor	NON-PREFERRED AGENTS Cinryze Ruconest Prior authorization is required	CRITERION**
HEPATITIS C AGENTS		
PREFERRED AGENTS Preferred status implementation: 1/1/17 ribavirin tablets Epclusa● (preferred for genotype 2,3,5 and 6) Zepatier● (preferred for genotype 1 and 4)	NON-PREFERRED AGENTS ribavirin capsules Daklinza● Harvoni● Pegasys▲ ● Peg-Intron▲ ● Olysio● Rebetol Ribasphere Sovaldi● Technivie● Viekira Pak● Viekira XR NR● Prior authorization is required	CRITERION** ●—Clinical criteria will still apply. Prior authorization available at: www.dmap.state.de.us/downloads/pharmacy/paforms/Hepatitis.C.Prior.Authorization.Form.pdf ▲— indicates that the manufacturer does not participate in all DMMA programs. NR indicates that a product has not been reviewed by the P&T Committee, but DMMA policy states that new products will be non-preferred until reviewed by the Committee.

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HISTAMINE II RECEPTOR BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/17 famotidine tablets ranitidine syrup / tablets	NON-PREFERRED AGENTS Prior authorization is required cimetidine famotidine suspension nizatadine ranitidine capsules Zantac 75	CRITERION***
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HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/17 acarbose	NON-PREFERRED AGENTS Prior authorization is required Glyset Precose	CRITERION***
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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS Preferred status implementation: 1/1/17 Bydureon(step-edit) Byetta (step-edit) Jentadueto (step-edit) Kombiglyze XR (step-edit)	NON-PREFERRED AGENTS Prior authorization is required alogliptin ● alogliptin-metformin ● alogliptin-pioglitazone ● Janumet ● Janumet XR ● Januvia	CRITERION*** Step-edit : For preferred products, no PA required if client has Type II diagnosis and metformin use in last 90 days. ●—Clinical criteria apply for non-preferred products. Forms available at: www.dmap.state.de.us/downloads/pharmacy/paforms/Incretin_Mimetics.pdf
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HYPOGLYCEMICS, INSULINS

PREFERRED AGENTS Preferred status implementation: 1/1/17 Humalog▲ Humalog Mix▲ Humulin▲ Lantus	NON-PREFERRED AGENTS Prior authorization is required Afrezza Apidra Humulin R 500 Kwikpen Toujeo SoloStar Tresiba FlexTouch	CRITERION*** ▲— indicates that the manufacturer does not participate in all DMMA programs.
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HYPOGLYCEMICS, MEGLITINIDES

PREFERRED AGENTS Preferred status implementation: 1/1/17 nateglinide repaglinide	NON-PREFERRED AGENTS Prior authorization is required repaglinide/metformin Prandin	CRITERION***
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HYPOGLYCEMICS, METFORMINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 glipizide-metformin glyburide-metformin metformin metformin ER (gen Glucophage XR)	Prior authorization is required metformin ER (gen Fortamet) Glucovance Glumetza Riomet	<u>2 preferred medications are required before a non-preferred will be approved</u>

HYPOGLYCEMICS, SGLT2s

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 Jardiance Synjardy	Prior authorization is required Farxiga Invokana Invokamet Xigduo XR	<u>Trial of preferred medication required before non-preferred medication will be approved</u>

HYPOGLYCEMICS, TZDs

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 pioglitazone	Prior authorization is required pioglitazone/glimepeptide pioglitazone/metformin Actoplus Met XR Avandia	

IMMUNOMODULATORS, ATOPIC DERMATITIS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 Elidel •	Prior authorization is required tacrolimus •	•—Clinical criteria will still apply. Prior authorizations available at: www.dmap.state.de.us/downloads/pharmacy/paforms/Pimecrolimus.and.Tacrolimus.pdf —Quantity limits are in place: 400 grams per year

IMMUNOMODULATORS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 imiquimod	Prior authorization is required Zyclara	

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INTRANASAL RHINITIS AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 azelastine (gen. Astelin) fluticasone Rx ipratropium	Prior authorization is required azelastine (gen. Astepro) budesonide flunisolide fluticasone OTC mometasone olopatadine triamcinolone	Beconase AQ Dymista Omnaris Qnasl Veramyst Zetonna <u>2 preferred medications are required before a non-preferred will be approved</u>

LEUKOTRIENE RECEPTOR ANTAGONISTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 montelukast tablet, chew tabs●	Prior authorization is required montelukast granules ● zafirlukast ● Accolate ● Singulair Gran Pack ● Zyflo CR ●	<u>2 preferred medications are required before a non-preferred will be approved</u> ●—Clinical criteria apply. ICD-10 code for asthma indication may create a system-generated approval for montelukast or Accolate Prior authorizations available at: www.dmap.state.de.us/downloads/pharmacy/paforms/leukotriene.pdf

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 clindamycin capsules clindamycin solution (preferred for client younger than 10)	Linezolid Sivextro	

LIPOTROPICS, OTHER

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 colestipol cholestyramine/aspartame fenofibrate (except 50 and 150 mg) gemfibrozil niacin ER Niaspan 750 mg	Prior authorization is required cholestyramine/sucrose fenofibrate 50,150 mg fenofibric acid omega-3 acid ethyl esters Antara▲	<u>2 preferred medications are required before a non-preferred will be approved</u> Juxtapid Kynamro Niacor Praluent Repatha Vascepa Welchol▲ Zetia ▲— indicates that the manufacturer does not participate in all DMMA programs.

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LIPOTROPICS, STATINS

PREFERRED AGENTS Preferred status implementation: 1/1/17 atorvastatin lovastatin pravastatin simvastatin	NON-PREFERRED AGENTS Prior authorization is required amlodipine/atorvastatin fluvastatin fluvastatin ER rosuvastatin	CRITERION*** Altoprev Liptruzet Livalo Vytorin 2 preferred medications are required before a non-preferred will be approved -Once daily dosing required
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MACROLIDES

PREFERRED AGENTS Preferred status implementation: 1/1/17 azithromycin	NON-PREFERRED AGENTS Prior authorization is required clarithromycin erythromycin E.E.S. 200 suspension E.E.S. 400 tablets Eryped	CRITERION***
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MULTIPLE SCLEROSIS

PREFERRED AGENTS Preferred status implementation: 1/1/17 Aubagio Avonex ▲ Betaseron Copaxone 20mg Gilenya Rebif	NON-PREFERRED AGENTS Prior authorization is required glatiramer Ampyra● Copaxone 40mg Extavia	CRITERION*** ▲ – indicates that the manufacturer does not participate in all DMMA programs. ● – Ampyra has a clinical prior authorization that is required despite the medication's status as preferred or non-preferred. Forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Ampyra.pdf
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NEUROPATHIC PAIN

PREFERRED AGENTS Preferred status implementation: 1/1/17 duloxetine (gen. Cymbalta) gabapentin lidocaine 5% patch●	NON-PREFERRED AGENTS Prior authorization is required duloxetine (gen. Irenka) Gralise Horizant	CRITERION*** ● lidocaine 5% patch (greater than 2 patches a day requires prior auth) www.dmap.state.de.us/downloads/pharmacy/paforms/Lidocaine.Topical.Patch.pdf
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NITROFURAN DERIVATIVES

PREFERRED AGENTS Preferred status implementation: 1/1/17 nitrofurantoin	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
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NSAIDs, ORAL/TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***		
Preferred status implementation: 1/1/17 ibuprofen indomethacin IR ketorolac meloxicam tablets naproxen tablets sulindac	celecoxib● diclofenac IR, DR, ER, topical diclofenac/misoprostol diflunisal etodolac IR, SR fenoprofen ▲ flurbiprofen indomethacin ER ketoprofen IR, ER meclofenamate mefenamic acid	meloxicam suspension nabumetone naproxen sodium IR, ER naproxen DR, suspension oxaprozin piroxicam tolmetin	Duexis ^{NR} Flector Indocin Pennsaid Sprix Tivorbex Vimovo Vivlodex ^{NR} Zipsor Zorvolex	<u>2 preferred medications are required before a non-preferred will be approved</u> ● – indicates that a clinical prior authorization is required. Forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Cox-2.Celecoxib.valdecoxib.pdf ▲ – indicates that the manufacturer does not participate in all DMMA programs.

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**	
Preferred status implementation: 1/1/17 azelastine cromolyn olopatadine	epinastine Alocril Alomide Alrex Bepreve	Emadine Lastacaft Pataday Pazeo	<u>2 preferred medications are required before a non-preferred will be approved</u>

OPHTHALMICS, ANTI-INFLAMMATORIES

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***		
Preferred status implementation: 1/1/17 dexamethasone diclofenac fluorometholone flurbiprofen ketorolac prednisolone acetate	prednisolone sodium phosphate Durezol Flarex FML Forte FML S.O.P.	Ilevro Lotemax Maxidex Pred Mild	Prior authorization is required	<u>2 preferred medications are required before a non-preferred will be approved</u>

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OPHTHALMICS, ANTIBIOTICS

PREFERRED AGENTS		NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required	
bacitracin/polymyxin	sulfacetamide	bacitracin	2 preferred medications are required before a non-preferred will be approved
ciprofloxacin	tobramycin	gatifloxacin	
erythromycin	Moxeza	levofloxacin	
gentamicin	Tobrex ointment	neomycin/bacitracin/polymyxin	
ofloxacin	Vigamox	neomycin/polymyxin/gramicidin	
polymyxin/trimethopm		Zymar	

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

PREFERRED AGENTS		NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required	
neomycin/polymyxin/ dexamethasone	Blephamide	neomycin/polymyxin/HC	2 preferred medications are required before a non-preferred will be approved
sulfacetamide/ prednisolone	Pred-G Tobradex suspension	neomycin/bacitracin/ polymyxin/HC tobramycin/dexamethasone suspension	Please note: Brand name drugs with a generic available are considered nonpreferred unless listed in bold.

OPHTHALMICS, GLAUCOMA AGENTS

PREFERRED AGENTS		NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required	
Brimonidine 0.1%	Alphagan P 0.15%	apraclonidine betaxolol bitamoprost brimonidine 0.15% metipranolol phospholine iodide Alphagan P 0.1% Cosopt PF Iopidine Lumigan Rescula Zioptan	2 preferred medications are required before a non-preferred will be approved Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. Please note: Brand name drugs with a generic available are considered nonpreferred unless listed in bold.

OPIATE DEPENDENCE TREATMENTS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS		NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required	For prior authorization forms, please visit: www.dmap.state.de.us/downloads/pharmacy/paforms/Buprenorphine.pdf

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OPIATE OVERDOSE TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	
Preferred status implementation: 1/1/17 naloxone Narcan nasal spray	Non-PREFERRED AGENTS Prior authorization is required Evzio	

OTIC ANTI-INFECTIVES, ANESTHETICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 acetic acid/aluminum acetic acid	NON-PREFERRED AGENTS Prior authorization is required acetic acid/hydrocortisone	<u>2 preferred medications are required before a non-preferred will be approved</u>

OTIC ANTIBIOTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 ciprofloxacin neomycin / polymyxin / hydrocortisone Ciprodex	NON-PREFERRED AGENTS Prior authorization is required ofloxacin Cipro HC Coly-Mycin S Otiprio ^{NR} Otovel ^{NR}	

PAH AGENTS, ORAL & INHALED

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 sildenafil● Letairis ●▲ Tracleer ● Ventavis ●	NON-PREFERRED AGENTS Prior authorization is required Adcirca ● Adempas Opsumit Orenitram ER Revatio Suspension Tyvaso ●	 ●—Clinical criteria will still apply. For prior authorization forms, please visit: www.dmap.state.de.us/downloads/pharmacy/paforms/Sildenafil.pdf ▲— indicates that the manufacturer does not participate in all DMMA programs.

PANCREATIC ENZYMES

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 Creon Zenpep	NON-PREFERRED AGENTS Prior authorization is required Pancreaze Pertzye Viokace	

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PENICILLINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**
PREFERRED status implementation: 1/1/17 amoxicillin ampicillin dicloxacillin penicillin G procaine	Prior authorization is required Moxatag	

PHOSPHATE BINDERS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**
PREFERRED status implementation: 1/1/17 calcium acetate Phoslyra Renagel▲ ● Renvela tablet●	Prior authorization is required Auryxia Eliphos Fosrenol ●	•—Clinical criteria will still apply: indicates that a prior authorization is required despite the medication's status as preferred or non-preferred. Forms available at: www.dmap.state.de.us/downloads/pharmacy/paforms/PhosphorousBinders.pdf ▲— indicates that the manufacturer does not participate in all DMMA programs.

PLATELET AGGREGATION INHIBITORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**
PREFERRED status implementation: 1/1/17 clopidogrel dipyridamole Aggrenox Brilinta	Prior authorization is required aspirin/dipyridamole ticlopidine Durlaza Effient Yosprala ^{NR} Zontivity	<u>2 preferred medications are required before a non-preferred will be approved</u>

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PRENATAL VITAMINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**
PREFERRED AGENTS Preferred status implementation: 1/1/17 Citranatal Assure Citranatal 90 DHA Citranatal Harmony Niva-Plus O-Cal PNV Folic Acid+Iron Prenatal Plus Prenatal Vitamin plus Low Iron Preplus Se-Natal 19 chewable Trinatal Rx1	NON-PREFERRED AGENTS Prior authorization is required All other prenatal products non-preferred	<u>2 preferred medications are required before a non-preferred will be approved</u>

PROGESTATIONAL AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**
PREFERRED AGENTS Preferred status implementation: 1/1/17 medroxyprogesterone acetate norethindrone acetate progesterone capsule Makena●	NON-PREFERRED AGENTS Prior authorization is required progesterone IM Crinone Depo-SubQ Provera Prometrium	•—Clinical criteria will still apply: indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred. Prior Authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/hydrogest.cap.Makena.pdf

PROTON PUMP INHIBITORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION**
PREFERRED AGENTS Preferred status implementation: 1/1/17 omeprazole Rx pantoprazole Nexium suspension (preferred for age 10 and under) Protonix suspension (preferred for age 10 and under)	NON-PREFERRED AGENTS Prior authorization is required esomeprazole magnesium esomeprazole strontium Lansoprazole ● omeprazole OTC tablets omeprazole / sodium bicarbonate● omeprazole suspension omeprazole magnesium OTC●	CRITERION** For non-preferred products, max of 60 days approval for GERD •—Clinical criteria will still apply: indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred. Prior Authorization forms available on the web at: www.dmap.state.de.us/information/paforms.html ●— indicates that the manufacturer does not participate in all DMMA programs.

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SEDATIVE HYPNOTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17 temazepam 15mg, 30mg zolpidem tablets	chloral hydrate eszopiclone estazolam flurazepam temazepam 7.5 ,22.5mg	triazolam zaleplon zolpidem ER zolpidem sublingual Belsomra	Edluar Hetlioz Rozerem Silenor Zolpimist	-Dose optimization when applicable: total quantity limit of one daily covered.

SKELETAL MUSCLE RELAXANTS

PREFERRED AGENTS	NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17 baclofen chlorzoxazone cyclobenzaprine methocarbamol tizanidine tablets	carisoprodol ● carisoprodol compound carisoprodol compound w/codeine ● cyclobenzaprine 7.5 mg cyclobenzaprine ER dantrolene	metaxalone orphenadrine tizanidine capsules Amrix Lorzone	<u>2 preferred medications are required before a non-preferred will be approved</u> Total quantity limit of 120 units of muscle relaxants per 30 rolling days.	●—Clinical criteria will still apply: indicates that a clinical prior authorization is required. Prior Authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Carisoprodol.pdf

STEROIDS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS			CRITERION***
Preferred status implementation: 1/1/17 betamethasone dipropionate betamethasone dipropionate/propylene glycol cream fluocinolone oil fluocinonide hydrocortisone hydrocortisone acetate mometasone temovate cream/ointment triamcinolone cream, lotion, ointment Capex shampoo ▲ Hydro Skin Scalpicin	aclometasone amcinonide betamethasone valerate clobetasol clocortolonedesonide desoximetasone diflorasone fluocinolone cream, ointment, shampoo, solution flurandrenolide fluticasone halobetasol	hydrocortisone butyrate hydrocortisone valerate prednicarbate triamcinolone aerosol Clodan Cordran	Halog Pandel Sernivo Synalar Texacort Topicort Ultravate	<u>2 preferred medications are required before a non-preferred will be approved</u> ▲— indicates that the manufacturer does not participate in all DMMA programs.

DELAWARE MEDICAL ASSISTANCE PROGRAM (DMP) PREFERRED DRUG LIST (PDL)

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STIMULANTS AND RELATED AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
<p>Preferred status implementation: 1/1/17</p> <p>amphetamine salt combo ■ dexmethylphenidate IR■ dextroamphetamine IR tablets■ guanfacine ER ■ methylphenidate IR■ methylphenidate ER 24 tablets (Actavis Iblr 68084 and Watson Iblr 00591 only)■ methylphenidate CD methylphenidate ER tablets (generic Ritalin SR) modafinil</p> <p>Adderall XR (step-edit)■ Focalin XR ■ Methylin solution ■ Procentra ■ Quillivant XR■ Strattera Vyvanse ■</p>	<p>Prior authorization is required</p> <p>clonidine ER dexmethylphenidate ER dextroamphetamine ER■ dextroamphetamine-amphetamine ER dextroamphetamine solution methamphetamine■ methylphenidate chewable tablets methylphenidate ER 24 tablets (Kremers Urban Iblr 62175 and Mallinckrodt Iblr 00406) methylphenidate LA methylphenidate solution■</p>	<p>Aptensio XR Daytrana ● Evekeo Nuvigil ● Zenedzi</p> <p><u>2 preferred medications are required before a non-preferred will be approved</u></p> <p>Dose optimization required.</p> <p>●-Indicates that clinical criteria applies for <u>all</u> ages for drugs</p> <p>—Clinical criteria applies for clients over age 21. www.dmap.state.de.us/downloads/pharmacy/paforms/ADHD.Therapy.pdf</p> <p>Adderall XR new starts will pay electronically if the client has tried and failed Vyvanse first.</p> <p>Please note: Brand name drugs with a generic available are considered nonpreferred unless listed in bold. For Prior Authorization forms, please visit: www.dmap.state.de.us/information/paforms.html</p>

TETRACYCLINES

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
<p>Preferred status implementation: 1/1/17</p> <p>doxycycline monohydrate 50, 100 mg capsules minocycline capsules</p>	<p>Prior authorization is required</p> <p>demeclocycline doxycycline hyclate doxycycline monohydrate 75 mg capsules doxycycline monohydrate tablets minocycline ER</p>	<p>minocycline tablets tetracycline Doryx Morgidox Oracea Solodyn</p> <p><u>2 preferred medications are required before a non-preferred will be approved</u></p>

THYROID HORMONES

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
<p>Preferred status implementation: 1/1/17</p> <p>levothyroxine sodium tablets liothyronine sodium tablets Armour thyroid Cytomel NP Thyroid</p>	<p>Prior authorization is required</p> <p>levothyroxine sodium injection liothyronine sodium injection Thyrolar Tiosint</p>	

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ULCERATIVE COLITIS AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 mesalamine enema sulfasalazine sulfasalazine DR Apriso ▲ Canasa	Prior authorization is required balsalazide mesalamine enema kit Asacol HD Delzicol Dipentum Giazo Lialda Pentasa	<u>2 preferred medications are required before a non-preferred will be approved</u> ▲— indicates that the manufacturer does not participate in all DMMA programs.

VASODILATORS, CORONARY

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 isosorbide dinitrate IR isosorbide mononitrate isosorbide mononitrate ER nitroglycerin transdermal Nitrostat sublingual	Prior authorization is required Isosorbide dinitrate ER nitroglycerin ER nitroglycerin translingual spray Dilatrate SR Isordil Nitro-Bid ointment Nitrolingual spray	

***Be advised this criterion is for FEE-FOR-SERVICE CLIENTS ONLY. Prior authorizations for clients enrolled with a Managed Care Organization (MCO) should be processed through the MCO following MCO criteria.

HighMark Health Options criteria can be reviewed at <https://www.highmarkhealthoptions.com/providers/priorauthorization>

UnitedHealthcare Community Plan criteria can be reviewed at www.uhccommunityplan.com/health-professionals/de/pharmacy-program.html